Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS302AGZ	A. BUILDING _____ B. WING _____	C 04/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY ALZHEIMER'S HOME	1821 NAVARRE LANE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an complaint investigation conducted at your facility on 2/23/10 to 4/5/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. One resident file was reviewed. Complaint #NV00024568 was substantiated with an unrelated deficiency. The following deficiency was identified:	Y 000		
Y 085 SS=F	449.199(1) Staffing-CG on duty all times NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility.	Y 085		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 085	Continued From page 1 This Regulation is not met as evidenced by: Based on observation and interview of 4/5/10, the facility operator failed to ensure a caregiver was on the premises at all times one or more residents is present. Five residents were present in the facility with the owner's friend while the owner was running an errand. The friend and owner reported she was not a caregiver. Severity: 2 Scope: 3	Y 085		